Health Quality & Safety Commission New Zealand

ARC collaborative workshop

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Reducing Harm From Falls

A national programme to reduce harm from falls in care settings

Objectives

Sharing/learning about careplanning by discussing:

- what I have learnt as clinical lead
- what the literature says
- what my thinking is for the future
- how we can work together and seek advice on ensuring the careplan is safe for the resident and for those delivering care.

What I have learnt

Hospitals

- No DHB careplans the same (study 2013)
- Majority relied on tick box lists
- No clear distinction between business as usual care and individualised patient falls strategies
- Little evidence that patient and family involved ,but those that did mainly suggest giving the patient an information pamphlet
- Difficult to see the link from findings in a falls risk assessment and the documented care
- Falls strategies difficult to see as mixed in with other cares
- Careplans not near the patient
- Signalling systems varied, not standardised even across one hospital
- Patient goals seldom mentioned
- Evaluation of strategies rarely mentioned
- Some gave instruction as to when a re-assessment would be required
- No careplan guidelines mentioned all the components in the list of universal precautions for falls prevention mentioned in Preventing Falls in Hospitals - *A Toolkit for Improving Quality of Care (RAND Corporation 2013)*

What I have learnt

Aged residential care visits so far:

- No careplans the same
- Updated in set cycles
- No clear distinction between business as usual care and individualised patient falls strategies
- Strong resident and family involvement
- Have seen the link from findings in a falls risk assessment and the documented care in the places I have visited
- Falls strategies difficult to see as mixed in with other cares
- Careplans not near the resident – usually buried in the notes
- Signalling systems varied, not always evident

But I have observed:

- excellent examples of implementing best practice strategies
- using interRAI to inform planning
- impressive efforts to analyse the triggers to falling
- a workforce that knows their residents well
- efforts to reduce/eliminate use of antipsychotic medications

What does the evidence tell us?

- Knowing which residents have risk factors for falls is not enough - you must do something about it
- Once risk assessment is completed, the careplan must address the identified risks
- Recognise the difference between care as usual and the identified needs of the resident
- Careplanning accounts for multiple types of clinical data rather than just relying on one specific piece of information (interRAI)
- Care needs to be individualised
- Each risk factor should have a corresponding plan of care
- Involve resident and family
- No one strategy works for all residents

Preventing Falls in Hospitals - A Toolkit for Improving Quality of Care (RAND Corporation 2013)

My thinking

A careplan must be current, individualised and reflect resident changes and risks:

- must involve the resident when able, and their family
- must be visible for all to see
- have reminders near the resident (can be described as a signaling system)
- be evaluated daily in the clinical notes
- be easy to read and emphasise the risks.

My thinking

Clinical handover

- Must address the risks and articulate the changes in care accordingly

Incidents

- Must be reported, analysed and managed so that the findings influence the future care given

Risk assessment

- Is continual and requires critical thinking not just a tool to be completed every three months, then the finding can truly influence the care
- A concept of care as usual needs to be reinforced and audited against.

So what is the problem?

Sounds simple doesn't it?

- We do not learn and share with each other often enough
- We are scared of standardisation and protective of our brand
- Struggle with the resources to update as the evidence moves
- Get hung up over privacy argument that stops making the careplan and goals visible to all and safer for the resident
- Struggle with analysis methodology when falls and harm occur
- Still an underlying belief in some that falls in aged care are inevitable and thus accepted as how it is.

Examples I can share

- The day my way
- Map of life
- How to analyse triggers to falling
- Room layout
- Using interRAI data
- What are your examples?

Discussion

Your turn…….

What can we do as a collaborative?

Do your careplans stand up to best practice?

Should we check them out?

Thank you